**12The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.**
**This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-317-9373. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.sdcleaguefunds.org or call 1-800-317-9373 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $ 0 | See the Common Medical Events chart below for your costs for services this plan covers. |
| **Are there services covered before you meet your deductible?** | Not Applicable. | This plan does not have a deductible. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Not Applicable. | This plan does not have an out-of-pocket limit on your expenses. |
| **What is not included in the out-of-pocket limit?** | Not Applicable. | This plan does not have an out-of-pocket limit on your expenses. |
| **Will you pay less if you use a network provider?** | Not Applicable. | This plan does not use a provider network. You can receive covered services from any provider. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | Not Covered | Not Covered | Under this plan, you pay 100% of these expenses, even in-network.<br>This Plan offers a $2,200 semi-annual ($4,400 annual maximum with continuing eligibility) Medical Spending Account (MSA). You must pay 100% of your medical expenses. However, you may apply for a distribution from your account for direct reimbursement of out-of-pocket medical expenses not covered by your primary insurance plan. To be eligible for reimbursement, the medical expense must be considered a tax-deductible medical expense under Section 213 of the Internal Revenue Code. A complete listing of potentially reimbursable medical expenses is outlined in IRS publication 502. You must be enrolled in another group health plan to be eligible for reimbursement. No reimbursement is allowed for individual market coverage purchased through the Affordable Care Act (ACA) Marketplace or Medicare. No reimbursement is allowed for health insurance premiums paid on a pre-tax basis.<br>If you do not have other group health plan coverage that meets the minimum value standard under the ACA, you will only be eligible for reimbursement of medically necessary dental and vision (including lenses and frames) expenses from this Plan. See the Summary of Benefits and Coverage from your primary group health plan to determine if it meets this standard.<br>Any unused account balances will be forfeited at the end of the coverage period. |
| | Specialist visit | Not Covered | Not Covered | |
| | Preventive care/screening/ immunization | Not Covered | Not Covered | |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Not Covered | Not Covered | |
| | Imaging (CT/PET scans, MRIs) | Not Covered | Not Covered | |
| **If you need drugs to treat your illness or condition** | Generic drugs | Not Covered | Not Covered | |
| | Preferred brand drugs | Not Covered | Not Covered | |
| | Non-preferred brand drugs | Not Covered | Not Covered | |
| | Specialty drugs | Not Covered | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Not Covered | Not Covered | |
| | Physician/surgeon fees | Not Covered | Not Covered | |
| **If you need immediate medical attention** | Emergency room care | Not Covered | Not Covered | |
| | Emergency medical transportation | Not Covered | Not Covered | |
| | Urgent care | Not Covered | Not Covered | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | Not Covered | Not Covered | |
| | Physician/surgeon fees | Not Covered | Not Covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Not Covered | Not Covered | Under this plan, you pay 100% of these expenses, even in-network.<br>This Plan offers a $2,200 semi-annual ($4,400 annual maximum with continuing eligibility) Medical Spending Account (MSA). You must pay 100% of your medical expenses. However, you may apply for a distribution from your account for direct reimbursement of out-of-pocket medical expenses not covered by your primary insurance plan. To be eligible for reimbursement, the medical expense must be considered a tax-deductible medical expense under Section 213 of the Internal Revenue Code. A complete listing of potentially reimbursable medical expenses is outlined in IRS publication 502. You must be enrolled in another group health plan to be eligible for reimbursement. No reimbursement is allowed for individual market coverage purchased through the Affordable Care Act (ACA) Marketplace or Medicare. No reimbursement is allowed for health insurance premiums paid on a pre-tax basis.<br>If you do not have other group health plan coverage that meets the minimum value standard under the ACA, you will only be eligible for reimbursement of medically necessary dental and vision (including lenses and frames) expenses from this Plan. See the Summary of Benefits and Coverage from your primary group health plan to determine if it meets this standard.<br>Any unused account balances will be forfeited at the end of the coverage period. |
| | Inpatient services | Not Covered | Not Covered | |
| **If you are pregnant** | Office visits | Not Covered | Not Covered | |
| | Childbirth/delivery professional services | Not Covered | Not Covered | |
| | Childbirth/delivery facility services | Not Covered | Not Covered | |
| **If you need help recovering or have other special health needs** | Home health care | Not Covered | Not Covered | |
| | Rehabilitation services | Not Covered | Not Covered | |
| | Habilitation services | Not Covered | Not Covered | |
| | Skilled nursing care | Not Covered | Not Covered | |
| | Durable medical equipment | Not Covered | Not Covered | |
| | Hospice services | Not Covered | Not Covered | |
| **If your child needs dental or eye care** | Children's eye exam | Not Covered | Not Covered | |
| | Children's glasses | Not Covered | Not Covered | |
| | Children's dental check-up | Not Covered | Not Covered | |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Cosmetic Surgery
- Dental Care (Adult)(Child)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)(Child)
- Routine foot care
- Weight loss programs
- All of the benefits listed in the Common Medical Events starting on page 2 except to the extent reimbursement is available for out-of-pocket expenses under the MSA.

**Other Covered Services**

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: The SDC-League Health Fund at 321 West 44th Street, Suite 804, New York, NY 10036 or call 1-800-317-9373. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

**Does this plan provide Minimum Essential Coverage? Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards? No**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-317-9373.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist *cost sharing* | N/A |
| Hospital (facility) *cost sharing* | N/A |
| Other *cost sharing* | N/A |

**This EXAMPLE event includes services like:**
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| | |
|---|---|
| **Total Example Cost** | **$12,700** |

**In this example, Peg would pay:** (This condition is not covered, so patient pays 100%.)

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $12,700 |
| **The total Peg would pay is** | **$12,700** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist *cost sharing* | N/A |
| Hospital (facility) *cost sharing* | N/A |
| Other *cost sharing* | N/A |

**This EXAMPLE event includes services like:**
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| | |
|---|---|
| **Total Example Cost** | **$5,600** |

**In this example, Joe would pay:** (This condition is not covered, so patient pays 100%.)

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $5,600 |
| **The total Joe would pay is** | **$5,600** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist *cost sharing* | N/A |
| Hospital (facility) *cost sharing* | N/A |
| Other *cost sharing* | N/A |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| | |
|---|---|
| **Total Example Cost** | **$2,800** |

**In this example, Mia would pay:** (This condition is not covered, so patient pays 100%.)

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $2,800 |
| **The total Mia would pay is** | **$2,800** |

**The Plan would not be responsible for any costs of these EXAMPLE covered services as benefits provided under this Plan are for a Medical Spending Account (MSA) only.** You may apply for reimbursement of unreimbursed out-of-pocket medical expenses from the MSA provided by the Plan.